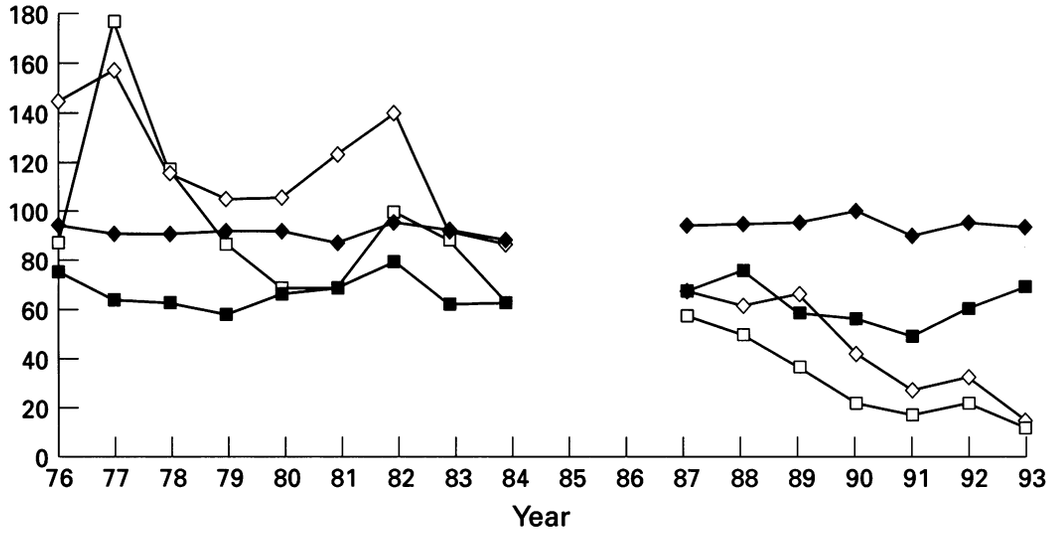

Female % of cases diagnosed on microscopy. *Female total cases of gonorrhoea.* *Male % of cases diagnosed on microscopy.* *Male total cases of gonorrhoea.*

particularly in women (29% in 1991 c.f. 70% in 1970).[1] We have data comparing diagnosis by microscopy and culture for most years from 1976. In all our data, the figures given are for the overall sensitivity of microscopy, and do not differentiate between sites of sampling.

Over the period for which data are available, the total number of cases of gonorrhoea has fallen from a peak of 333 in 1977, to only 21 in 1993. This fall has not been matched by a fall in the sensitivity of microscopic diagnosis apart from one year (1991), which we attribute to a change in personnel.

Of male cases of gonorrhoea 11/12 (91·7%) were diagnosed by microscopy in 1993 compared with 135/144 (93·8%) in 1976 (no significant difference: p = 0·98).

Of female cases of gonorrhoea 6/9 (66·7%) were diagnosed by microscopy in 1993 compared with 65/77 (74·7%) in 1976 (no significant difference: p = 0·79).

In this genitourinary (GUM) clinic most microscopy is done by the nursing staff, who are trained by more experienced members of the nursing team. Over this period training has been given mostly by one individual, which may also influence the relative constancy of the diagnostic sensitivity. In addition, our slides are retained until the results of culture are available, and any culture positive, slide negative cases are reviewed, providing useful feedback.

Although slide positive culture negative data are not included in the graph, there have been instances where a discrepancy between microscopy and culture has highlighted a problem with culture medium. Communication between the physicians, nursing and laboratory staff is obviously very important in alerting others if there is a high likelihood of a positive culture. In this clinic we also have an arrangement that any "slide positive" cases are cultured for a further 24 hours if no growth is seen initially, and this system has meant that some slow growing strains have been isolated. More recently, arrangements have been made for a review of slides by the microbiologists in cases where there has been a discrepancy.

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1 Evans JK, Mercey DE, French PD, Prince MV. Audit of diagnosis of gonorrhoea at first visit to a London genitourinary medicine clinic. *Genitourinary Med* 1994;70:291–2.

It could be more serious than you think!

A 25 year old patient presented to this department on 5 April 1994 with a small lump in the left inguinal region since December 1993. He had no other associated symptoms, no history of trauma to the lower limbs, and no history of sex abroad.

On examination he had an enlarged (about 2 cm) very firm, non-tender lymph node in the left inguinal region. There was no other associated lymphadenopathy or hepatosplenomegaly. The rest of the examination was unremarkable; in particular there were no lesions found on the lower limbs. Syphilis serology was negative and cultures for *Neisseria gonorrhoeae, Chlamydia trachomatis* and herpes simplex virus were all negative. Gram stain of a urethral smear was unremarkable. An ultrasound of the abdomen showed normal liver and pancreas, and there was no intra-abdominal lymphadenopathy. An ultrasound of the scrotum showed normal testes and epididymis.

On 19 April 1994 biopsy was performed, which revealed T immunoblastic (high grade) lymphoma.

This case highlights the importance of keeping an open mind about the differential diagnosis, and considering an urgent biopsy in an enlarged inguinal lymph node which cannot be explained by a local identifiable cause.

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